NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
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Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

May 9, 2018

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Daniel Guenzburger, Esq.
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, New York 10007

Juliana Kanji, M.D
775 Park Avenue, Suite 154
Huntington, New York 11743

Jordan Fensterman, Esq.
Abrams, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP
111 Marcus Avenue, Suite
Lake Success, New York 11042

RE: In the Matter of Juliana Kanji, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.18-104) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

[redacted]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: cac

Enclosure

STATE OF NEW YORK: DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF JULIANA KANJI, M.D.	DETERMINATION AND ORDER 18-104

This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("Department"). Juliana Kanji, M.D. ("Respondent") was served with a Notice of Hearing ("NOH") and Statement of Charges ("SOC")[1] dated June 16, 2017. A copy of the NOH and SOC is attached to this Determination and Order as Appendix 1. Hearings were held pursuant to N.Y. Public Health Law ("PHL") §230 and New York State Admin. Proc. Act §§301-307 and 401. The hearings were held at the Offices of the New York State Department of Health, at 90 Church Street, New York, New York. Cassandra E. Henderson, M.D. - *Chair*, Jonathan Ecker, M.D., and Joan Martinez-McNicholas, duly designated members of the State Board for Professional Medical Conduct ("Board"), served as the Hearing Committee ("Committee") in this matter. Kimberly A. O'Brien, Administrative Law Judge ("ALJ"), served as the Administrative Officer. The Department appeared by Richard J. Zahnleuter, Esq., General Counsel, by Daniel Guenzburger, Associate Counsel and Courtney Berry, Associate Counsel.[2] The Respondent appeared by Jordan Fensterman, Esq., and Michael Kelton, Esq. of Abrams, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP. Evidence was

[1] The Department withdrew the factual allegations and specification of charges related to Patient E & F on October 17, 2017 [Ex. 1; Tr. 344, 506]

[2] Ms. Berry appeared at the Pre-Hearing Conference and at the first day of hearing, July 25, 2018. Upon consent, scheduled hearing dates in August were adjourned because Ms. Berry had a dire family medical emergency. Mr. Guenzburger took over the case from Ms. Berry [Tr. 201].

received, including witnesses who were sworn or affirmed, and a transcript of this proceeding was made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Notice of Hearing Statement of Charges	June 16, 2017
Pre-Hearing Conference:	July 24, 2017
Hearing Dates:	July 25, 2017 October 17, 2017 November 17, 2017 December 12, 2017
Submission of Briefs	January 30, 2018
Deliberations Dates:	March 8, 2018

STATEMENT OF THE CASE

The Department alleged that Respondent failed to: appropriately evaluate, assess, diagnose and treat; appropriately prescribe; perform appropriate examinations and/or follow-up and/or refer the patient(s) for testing; coordinate care with other providers; and maintain adequate patient records [Ex. 1]. The Department charged the Respondent with seven specifications of professional misconduct relating to the care and treatment she provided to four patients: Patient A, Patient B, Patient C and Patient D. The Department charged in its first specification of misconduct that Respondent practiced the profession of medicine with negligence on more than one occasion, and in its second specification of misconduct that Respondent practiced medicine with incompetence on more than one occasion, as it relates to all

four patients, N.Y. Educ. Law §6530 (3), §6530(5). Negligence is defined as "the failure to exercise the care that would be exercised by another physician" and a "deviation from acceptable medical standards in the treatment of a patient".[3] Incompetence is defined as "a lack of skill or knowledge necessary to practice medicine". In its third specification of misconduct the Department alleged that the Respondent practiced medicine with "gross negligence on a particular occasion" in the care and treatment of Patient B, N.Y. Educ. Law §6530(4). Gross negligence is defined as "negligence which involves a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequences to the patient. Finally, the Department alleged in its fourth through seventh specifications of misconduct that Respondent failed to "maintain a record that accurately reflects the evaluation and treatment" for each of the four patients, N.Y. Educ. Law §6530 (32). The Respondent denied each of the factual allegations and specifications.

FINDINGS OF FACT

The following Findings of Fact ("FOF") were made after a review of the entire record in this matter. Citations in brackets, which refer to transcript page numbers ["Tr."] and exhibits ["Ex."] that were accepted into evidence, represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings are unanimous unless otherwise stated.

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[3] The Committee used the explanations contained in the *"Definitions of Professional Misconduct under the New York State Education Law"* ("memorandum") in reaching its determination [ALJ Ex. 3]. The parties were provided with a copy of the memorandum. At the outset of the hearing on July 25, 2017, Dr. Henderson, *Chair*, advised the parties that the Committee may use the memorandum to assist them in making a determination and the parties were invited to "comment or dispute" the definitions contained in the memorandum before the last day of hearing; neither party made a submission [Tr. 4-5; ALJ Ex. 3].

1. Respondent was authorized to practice medicine in New York State on or about August 31, 1987, by the issuance of license number 172087 by the New York State Education Department [Ex. 2].

2. Respondent provides outpatient psychiatric treatment at her private office located in Huntington, New York ("office"). She employs three social workers to assist her in her practice and she accepts most types of insurance including Medicaid. Respondent treats children, adolescents and adults with chronic and often severe psychiatric problems. [Tr. 523-524, 576-577, 603-604, 686, 690].

3. The Department requested and Respondent provided several patient records for patients Respondent treated in her office ("patient records" or "records") including Patient A, Patient B, Patient C and Patient D. The records were not in chronological order [Tr. 541-544].

4. Respondent treated Patient A from November 15, 2012 to December 2013 and maintained a patient record. [Ex.3, Ex. 3A, Ex. D; Tr. 370-389, 390- 392, 397-399, 408-411, 580-584, 589-590, 596-607].

5. Respondent treated Patient B from October 2003 to May 2012 and maintained a patient record. [Ex. 4, Ex. 4A; Tr. 413-414, 416-420, 423, 440-449, 456-457, 461-466, 657-690].

6. In December 2005 Patient C was 15 years old. During December 2005 to September 2008, at times when Patient C was not in a group home or in the hospital, Respondent treated Patient C and maintained a patient record [Ex. 5, Ex.5A; Tr. 467-468, 470-471, 475- 480, 714-723].

7. In June 2007 Patient D was 10 years old. During June 2007 to July 2008, at times when Patient D was not a patient in Sagamore Child Psychiatric Center, Respondent treated Patient

D and maintained a patient record [Ex. 6, Ex. 6A, Ex. C; Tr. 481-488, 490-496, 502-504, 728- 737].

8. Respondent has a reputation as a competent, hardworking and compassionate psychiatrist [Ex I-1, Ex. I-2, Ex. I-3, Ex. I-4; Tr. 366 -367, 494-495, 529-533, 595].

DISCUSSION

As required by PHL §230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Statement of Charges were more probable than not. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department (*See* Prince, Richardson on Evidence § 3-206 [Farrell 11th ed]). The Department presented one witness, Shari Luskin, M.D. The Respondent testified on her own behalf and presented Michael Schwartz, M.D. The Hearing Committee found that all the witnesses provided credible testimony.

Testimony of Dr. Luskin

The Department's expert witness, Dr. Luskin, is an experienced psychiatrist. She is a solo practitioner with a private office based practice in Manhattan, and she specializes in "women's reproductive mental health" and treats an adult female population [Ex. 9; Tr. 17]. She does not accept any insurances and she does not employ social workers. Dr. Luskin is also a "clinical professor of psychiatry, obstetrics, gynecology and reproductive science at the Mount Sinai School of Medicine" [Tr. 18].

The Department asked Dr. Luskin to review the patient records and provide an opinion as to whether the Respondent had practiced within acceptable medical standards. Dr. Luskin testified that the records she reviewed were not in order and that a subsequent treating physician

would not know what care and treatment Respondent provided to the patients; even if the records were in order it would not change her opinion [Tr. 20-23, 203, 290]. She opined that based on her review of the records Respondent failed to meet acceptable standards of care including that Respondent failed to appropriately prescribe, failed to perform appropriate evaluations, failed to order lab work/testing and follow up, failed to coordinate patient care with other providers, and failed to keep appropriate records.

Albeit the references were out of order, on cross examination Respondent's counsel referred Dr. Luskin to numerous places in the patient records where Respondent had documented appropriate patient care and treatment. Specifically, Respondent's patient records contained treatment histories; written patient social and medical histories and progress notes; patient prescriptions written by Respondent and other providers; and contacts with and coordination of patient care with other providers including the social workers Respondent employs, primary care physicians ("PCPs"), schools, families, inpatient treatment centers, outpatient clinics etc. [See FOF 4-7].

While the Hearing Committee found that the Department's expert witness was qualified to provide an opinion about the quality of the care Respondent provided to these patients, the Hearing Committee believed that because Dr. Luskin reviewed the patient records without putting them in order, she could not provide an informed opinion about whether the Respondent met acceptable standards of care. The Hearing Committee also found that the nature of Dr. Luskin's psychiatry practice and the patient population she treats is vastly different from that of Respondent, and Dr. Luskin did not appear to take this into consideration when forming an opinion about the care and treatment Respondent provided to her patients. The Hearing Committee believes that Dr. Luskin's opinion about whether Respondent met acceptable

standards of care was based more on the care, treatment and recordkeeping she herself provides in her practice, or what she would expect her medical students to provide. But, Dr. Luskin's opinion should have been based on whether Respondent met minimum acceptable standards of care for a psychiatrist working in an office based private practice setting treating a patient population with chronic and often severe psychiatric problems.

Testimony of Dr. Schwartz

Respondent's expert witness, Dr. Schwartz, is an experienced psychiatrist and a solo practitioner with a private office in Melville New York.[4] He primarily treats adult patients, both men and women, and he does not accept many types of insurance [Tr. 358-359]. While he does not employ social workers he regularly consults with social workers. He "sees some patients for social workers" and has longstanding ties with social workers from his work at both Stony Brook University Medical Center ("Stonybrook") and Huntington Hospital [Tr. 357]. For approximately fifteen years, Dr. Schwartz worked in both the hospital emergency room and outpatient department at Stonybrook and for a time he was the "director of medical education for students and residency training" [Tr. 355-356]. Until recently he was the chairman of the psychiatric department at Huntington Hospital. Dr. Schwartz had worked with Respondent at Huntington Hospital, and he refers patients to Respondent because she accepts most insurances including Medicaid, and she treats children, adolescents and adults with chronic often severe psychiatric conditions.

Respondent's counsel provided Dr. Schwartz with the same patient records that were provided to Dr. Luskin, and he too was asked to provide an opinion about whether the Respondent had practiced within acceptable medical standards. The patient records were not in

[4] Melville is located near Huntington, New York [Tr. 357-359].

chronological order. Unlike Dr. Luskin, Dr. Schwartz organized the records before he conducted his review. He testified that this was necessary to form an opinion about the quality of the care Respondent provided to these patients, as well as whether the patient records contained appropriate information for subsequent treating physicians. "In order to get a sense of what's going on in the care of a patient, it's very helpful to start from the beginning and move through the record and see what's happening in the clinical course of the patient" [Tr. 364-365]. Dr. Schwartz testified that the patient records revealed that these patients had "subacute or chronic conditions" and were "significantly impaired or disabled" and were difficult to treat [365-366]. Based on his review of the patient records he found Respondent's care and treatment of the patients, as well as her recordkeeping met acceptable standards of care [FOF 4-7].

The Hearing Committee found that the Respondent's expert witness was well qualified to provide an opinion about the Respondent's care and treatment of the patients. The Hearing Committee believes that because Dr. Schwartz organized the patient records he was able to provide an informed opinion about Respondent's care and treatment of the patients, as well as her recordkeeping practices. The Committee noted that for many years Dr. Schwartz both worked and trained medical residents in a hospital and outpatient clinic setting, but in forming his opinion about whether Respondent met acceptable standards of care he distinguished between what is expected of a psychiatrist or resident working in a hospital or outpatient clinic from the care that a psychiatrist provides in a private practice setting to patients with chronic and often severe psychiatric issues and comorbidities [Tr. 364-366]. The Committee believes that Dr. Schwartz's opinion was appropriately based on whether Respondent met minimum acceptable standards of care expected of a psychiatrist working in a similar setting and with a similar patient

population. Accordingly, the Hearing Committee gave Dr. Schwartz's opinion significant weight in reaching their determination.

Testimony of Respondent

Respondent is an experienced psychiatrist who has practiced in many settings including hospitals, nursing homes and outpatient mental health clinics and she has worked with different patient populations. While the Respondent obviously has a stake in the outcome of this hearing, the Committee found that Respondent provided cogent and credible testimony about her psychiatric practice. Respondent testified that she often sees more than twenty patients a day and she is at the office ten hours a day. She works closely with the social workers she employs, and the nature of her practice requires that she coordinate care for the patients with, among others, PCPs, families, schools, inpatient treatment centers and/or outpatient clinics. Respondent does not dispute that the patient records were out of order when the Department received them and she acknowledged that the patient records could have been more thorough. Respondent testified that two or three years ago she switched from hand written medical records to electronic records and her record keeping has improved.

CONCLUSIONS

The Department had the burden of proof. The Department's allegations of negligence and incompetence were simply not supported by the record. While the Committee believes that the patient records were sloppy and disorganized and that Respondent could benefit from a record keeping course, the Committee concluded that the patient records met minimum acceptable standards. After due and careful consideration of the entire record the Committee concludes that none of the factual allegations or specifications of misconduct against Respondent have been established by a preponderance of the evidence. The Hearing Committee made these conclusions

pursuant to the factual findings listed above, and all conclusions resulted from a unanimous vote of the Hearing Committee. Accordingly, the Hearing Committee dismissed all seven specifications of misconduct.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The first through seventh specifications of professional misconduct set forth in the Statement of Charges are **DISMISSED;**

2. This Determination and Order shall be effective upon service on the Respondent pursuant to Public Health Law Section 230(10)(h).

DATED: New York
May 7, **2018**

[redacted]

CASSANDRA HENDERSON, M.D. (CHAIR)
JONATHAN ECKER, M.D.
JOAN MARTINEZ-MCNICHOLAS

To: Daniel Guenzburger
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APPENDIX I

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF **Juliana Kanji, M.D.**	NOTICE OF HEARING

TO: Juliana Kanji, M.D.
775 Park Avenue
Huntington, NY 11743

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on July 25, 2017, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th Floor, NY, NY 10007, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel who shall be an attorney admitted to practice in New York state. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses

and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

YOU ARE HEREBY ADVISED THAT THE ATTACHED CHARGES WILL BE MADE PUBLIC FIVE BUSINESS DAYS AFTER THEY ARE SERVED.

Department attorney: Initial here [redacted]

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Riverview Center, 150 Broadway - Suite 510, Albany, NY 12204-2719, ATTENTION: HON. JAMES HORAN, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the

Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

[redacted]

DATE: June 16, 2017

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct

New York, NY

Inquiries should be directed to:
Courtney Berry
Associate Counsel
Bureau of Professional Medical Conduct
90 Church Street
New York, NY 10007
(212) 417-4450

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

Juliana Kanji, M.D.

STATEMENT

OF

CHARGES

Juliana Kanji, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 31, 1987, by the issuance of license number 172087 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A at her Huntington, N.Y. office from in or about 2008 through in or about December 2013. Respondent deviated from accepted medical standards in that:

1. Respondent failed to appropriately evaluate, assess, diagnose, and treat Patient A.
2. Respondent failed to perform appropriate examinations and/or follow-up and/or refer Patient A for testing.
3. Respondent failed to appropriately prescribe for Patient A.
4. Respondent failed to coordinate Patient A's care with other providers.
5. Respondent failed to maintain an adequate medical record for Patient A.

B. Respondent treated Patient B at her Huntington, N.Y. office from in or about October 2003 through in or about May 2012. Respondent deviated from accepted medical standards in that:

1. Respondent failed to appropriately evaluate, assess, diagnose, and treat Patient B.

2. Respondent failed to appropriately prescribe for Patient B.
3. Respondent failed to perform appropriate examinations and/or follow-up and/or refer Patient B for testing.
4. Respondent failed to coordinate care with Patient B's other providers.
5. Respondent failed to maintain an adequate medical record for Patient B.

C. Respondent treated Patient C at her Huntington, N.Y. office from in or about 2005 through in or about 2008. Respondent deviated from accepted medical standards in that:

1. Respondent failed to appropriately evaluate, assess, diagnose, and treat Patient C.
2. Respondent failed to appropriately prescribe for Patient C.
3. Respondent failed to coordinate care with Patient C's school and other providers.
4. Respondent failed to maintain an adequate medical record for Patient C.

D. Respondent treated Patient D at her Huntington, N.Y. office from in or about June 2007 through in or about July 2008. Respondent deviated from accepted medical standards in that:

1. Respondent failed to appropriately evaluate, assess, diagnose, and treat Patient D.
2. Respondent failed to perform appropriate examinations and/or follow-up and/or refer Patient D for testing.
3. Respondent failed to coordinate Patient D's care with other providers and/or Child Protective Services.
4. Respondent failed to appropriately prescribe for Patient D.
5. Respondent failed to maintain an adequate medical record for Patient D.

E. Respondent treated Patient E at her Huntington, N.Y. office from in or about ~~October~~ May 2007 through in or about April 2008. Respondent deviated from accepted medical standards in that:

1. Respondent failed to appropriately evaluate, assess, diagnose, and treat Patient E.
2. Respondent failed to appropriately prescribe for Patient E.
3. Respondent failed to perform appropriate examinations and/or follow-up and/or refer Patient E for testing.
4. Respondent failed to coordinate care with Patient E's other providers.
5. Respondent failed to maintain an adequate medical record for Patient E.

F. Respondent treated Patient F at her Huntington, N.Y. office from in or about ~~May~~ October 2007 through in or about February 2009. Respondent deviated from accepted medical standards in that:

1. Respondent failed to appropriately evaluate, assess, diagnose, and treat Patient F.
2. Respondent failed to perform appropriate examinations and/or follow-up and/or refer Patient F for testing.
3. Respondent failed to appropriately prescribe for Patient F.
4. Respondent failed to maintain an adequate medical record for Patient F.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

1. Paragraphs A through F and their subparagraphs.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

2. Paragraphs A through F and their subparagraphs.

THIRD SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

3. Paragraph B and its subparagraphs.

FOURTH THROUGH NINTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

4. Paragraph A and A5.
5. Paragraph B and B5.

6. Paragraph C and C4.

7. Paragraph D and D5.

~~8. Paragraph E and E5.~~ VOD 10/17/17 w.th

~~9. Paragraph F and F4.~~ VOD 10/17/17 w.th

DATE: June 16, 2017
New York, New York

[redacted]

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct